

# THErapy DALLAS

Psychological Services for Children, Adolescents, and Adults  
12800 Hillcrest A124, Dallas, TX 75230 • 214-755-6119 • www.therapydallas.com

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## AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION\*

PATIENT'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

I, \_\_\_\_\_ hereby give my consent to Therapy Dallas to release and receive personal health information contained in my Clinical Record regarding:

mental health     medical history     family history     other: \_\_\_\_\_

To/from:

Psychiatrist: \_\_\_\_\_

Other: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Other: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Prior Therapist: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

for the purpose(s) of ("Consultation" if left blank):  
\_\_\_\_\_

In addition to authorizing my therapist to consult with the above-listed individuals, I also give my consent for the below Therapy Dallas therapists to exchange *with one another* personal health information contained in my Clinical Record, for the purposes of clinical consultation:

Kristen M. Ohlenforst, PhD

Kristin S. Bemis, MEd, LPC, RPT

Jaime D. Crowley, PhD

Ashley P. Scott, MS, LPC, RPT

Tabatha H. Melton, PhD

Jamie L. Pederson, LMSW

I understand that this authorization is valid for 1 year after the last date of service unless otherwise indicated here: \_\_\_\_\_. I understand that I may, via written request, withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization to individuals outside Therapy Dallas may be subject to redisclosure by the recipient, and may no longer be protected by this privacy rule.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\* Compliant with the *Health Insurance Portability and Accountability Act (HIPAA)*.